

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1352. BRAIN INJURY

Sec. 1352.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan, including, subject to this chapter, a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

- (1) a basic coverage plan under Chapter 1551;
 - (2) a basic plan under Chapter 1575;
 - (3) a primary care coverage plan under Chapter 1579;
- and

- (4) basic coverage under Chapter 1601.

(c) This chapter applies to group health coverage made

available by a school district in accordance with Section [22.004](#), Education Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 1, eff. September 1, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. [2929](#)), Sec. 1, eff. September 1, 2013.

Sec. 1352.002. EXCEPTION; APPLICATION TO QUALIFIED HEALTH PLAN. (a) This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1352.001](#).

(b) This chapter does not apply to a standard health benefit plan issued under Chapter [1507](#).

(c) To the extent that a change in law made to this chapter after January 1, 2013, would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. [2929](#)), Sec. 2, eff. September 1, 2013.

Sec. 1352.003. REQUIRED COVERAGES--HEALTH BENEFIT PLANS OTHER THAN SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury.

(b) A health benefit plan must include coverage for post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

(c) A health benefit plan may not include, in any annual or lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan.

(c-1) A health benefit plan may not limit the number of days of covered post-acute care, including any therapy or treatment or rehabilitation, testing, remediation, or other service described by Subsections (a) and (b), or the number of days of covered inpatient care to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury. The insured's or enrollee's treating physician shall determine whether treatment or care is medically

necessary for purposes of this subsection in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The determination is subject to review under Section [1352.006](#).

(d) Except as provided by Subsection (c) or (c-1), a health benefit plan must include the same amount limitations, deductibles, copayments, and coinsurance factors for coverage required under this chapter as applicable to other medical conditions for which coverage is provided under the health benefit plan.

(e) To ensure that appropriate post-acute care treatment is provided, a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who:

- (1) has incurred an acquired brain injury;
- (2) has been unresponsive to treatment; and
- (3) becomes responsive to treatment at a later date.

(f) A determination of whether expenses, as described by Subsection (e), are reasonable may include consideration of factors including:

- (1) cost;
- (2) the time that has expired since the previous evaluation;
- (3) any difference in the expertise of the physician or practitioner performing the evaluation;
- (4) changes in technology; and
- (5) advances in medicine.

(g) The commissioner shall adopt rules as necessary to implement this chapter.

(h) This section does not apply to a small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 2, eff. September 1, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. [2929](#)), Sec. 3, eff. September 1, 2013.

Sec. 1352.0035. REQUIRED COVERAGES--SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this section may be subject to deductibles, copayments, coinsurance, or annual or maximum amount limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum amount limits applicable to other medical conditions for which coverage is provided under the small employer health benefit plan.

(c) The commissioner shall adopt rules as necessary to implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 3, eff. September 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. 2929), Sec. 4, eff. September 1, 2013.

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED.

(a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider.

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage

in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. The commissioner shall prescribe by rule the basic requirements for the training described by this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 4, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.38, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.35, eff. January 1, 2016.

Sec. 1352.005. NOTICE TO INSURED AND ENROLLEES. (a) A health benefit plan issuer subject to this chapter, other than a small employer health benefit plan issuer, must annually notify each insured or enrollee under the plan in writing about the coverages described by Section 1352.003.

(b) The commissioner shall prescribe by rule the specific contents and wording of the notice required under this section.

(c) The notice required under this section must include:

(1) a description of the benefits listed under Section 1352.003;

(2) a statement that the fact that an acquired brain injury does not result in hospitalization or receipt of a specific treatment or service described by Section 1352.003 for acute care treatment does not affect the right of the insured or enrollee to receive benefits described by Section 1352.003 commensurate with the condition of the insured or enrollee; and

(3) a statement of the fact that benefits described by Section 1352.003 may be provided in a facility listed in Section 1352.007.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 5, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.39, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.36, eff. January 1, 2016.

Sec. 1352.006. DETERMINATION OF MEDICAL NECESSITY; EXTENSION OF COVERAGE. (a) In this section, "utilization review" has the meaning assigned by Section 4201.002.

(b) Notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under this code, a health benefit plan shall respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal. The person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document. To comply with the requirements of this section, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer. This subsection does not apply to a small employer health benefit plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 5, eff. September 1, 2007.

Sec. 1352.007. TREATMENT FACILITIES. (a) A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided, including:

(1) a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation hospital; and

(2) an assisted living facility regulated under Chapter 247, Health and Safety Code.

(b) This section does not apply to a small employer health benefit plan.

(c) The issuer of a health benefit plan, including a preferred provider benefit plan or health maintenance organization plan, that contracts with or approves admission to a service provider under this chapter may not, solely because a facility is licensed by this state as an assisted living facility, refuse to contract with or approve admission to that facility to provide services that are:

- (1) required under this chapter;
- (2) within the scope of the license of an assisted living facility; and
- (3) within the scope of the services provided under a CARF-accredited rehabilitation program for brain injury or another nationally recognized accredited rehabilitation program for brain injury.

(d) The issuer of a health benefit plan that requires or encourages insureds or enrollees to use health care providers designated by the plan shall ensure that the services required by this chapter that are within the scope of the license of an assisted living facility and that may be provided under a program described by Subsection (c)(3) are made available and accessible to the insureds or enrollees at an adequate number of assisted living facilities.

(e) A health benefit plan may not treat care provided in accordance with this chapter as custodial care solely because it is provided by an assisted living facility if the facility holds a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

(f) To ensure the health and safety of insureds and enrollees, the commissioner may require that a licensed assisted living facility that provides covered post-acute care other than custodial care under this chapter to an insured or enrollee with acquired brain injury hold a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 5, eff. September 1, 2007.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 370 (H.B. [2929](#)), Sec. 5, eff. September 1, 2013.

Sec. 1352.008. CONSUMER INFORMATION. The commissioner shall prepare information for use by consumers, purchasers of health benefit plan coverage, and self-insurers regarding coverages recommended for acquired brain injuries. The department shall publish information prepared under this section on the department's Internet website.

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 5, eff. September 1, 2007.